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An exploration into the possible factors that can prevent a General Practitioner from the early identification of an eating disorder in their patients/clients

Cadhla O'Sullivan

CARL Research Project
in collaboration with
The Eating Disorder Centre Cork



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What is Community-Academic Research Links?

Community Academic Research Links (CARL) is a community engagement initiative provided by University College Cork to support the research needs of community and voluntary groups/ Civil Society Organisations (CSOs). These groups can be grass roots groups, single issue temporary groups, but also structured community organisations. Research for the CSO is carried out free of financial cost by student researchers.

CARL seeks to:

- provide civil society with knowledge and skills through research and education;
- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- Enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

What is a CSO?

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Why is this report on the UCC website?

The research agreement between the CSO, student and CARL/University states that the results of the study must be made public through the publication of the final research report on the CARL (UCC) website. CARL is committed to open access, and the free and public dissemination of research results.

How do I reference this report?

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Table of contents:

Cover Sheet	1
Table of Contents	7
Chapter One: Introduction.....	9
Chapter Two: Literature and Policy Review	11
2.1: Introduction.....	11
2.2: Classification of Eating Disorders.....	11
2.3: Models of Healthcare in the Irish Healthcare System.....	13
2.4: GPs Role in Relation to Eating Disorders.....	16
2.5: Time Constraints.....	18
2.6 The Challenging Eating Disorder (ED) Patient/Client.....	19
2.7 Stigma.....	19
2.8 The Importance of Early Intervention in Eating Disorder Cases.....	20
2.9 Conclusion of the Literature Review.....	22
2.10 Introduction of the Policy Review.....	23
2.11 Irish Mental Health Policy History.....	23
2.12 A Vision for Change.....	26
2.13 UK Policy on Eating Disorders.....	26
2.14: International Policy on Eating Disorders.....	29
2.15: Conclusion of the Policy Review.....	32
Chapter Three: Methodologies.....	34
3.1: Introduction.....	34
3.2: A Qualitative Approach	34
3.3: Features of a Qualitative Approach.....	35
3.4: Data Collection and Analysis.....	35
3.41: Sampling	35
3.42: The Semi-Structured Interview	36
3.43: The Interview Process	36
3.44: Analysis	37
3.45: Advantages of the Interview	38
3.46: Disadvantages of the Interview.....	38

3.47: Ethical Issues	40
3.48: Community Research Links.....	40
3.49: Limitation	42
3.5: Conclusion of Methodology Chapter	43
Chapter Four: Findings and Analysis	44
4.1: Introduction	44
4.2: GPs Knowledge of Eating Disorders	44
4.3: Time Constraints.....	45
4.4: Integration of Services	46
4.5: The Challenging Eating Disorder Patient/Client	47
4.5 Stigma.....	48
4.6 Conclusion of Findings and Analysis Chapter	48
Chapter Five: Discussion and Recommendations.....	49
5.1: Education.....	49
5.2: Online Guidelines.....	49
5.3: integration and Coordination of Services.....	50
Chapter Six: Conclusion.....	51
Appendixes.....	58

Chapter One: Introduction

This study focuses on the range of factors that may prevent a General Practitioner from the early identification of an eating disorder (ED) in their patients/clients. A pilot study carried out by McDermott (2016) highlighted that GPs in the Cork area felt they did not have a broad knowledge base of eating disorders and how best to recognise and treat them (McDermott, 2016). As this research design is also being run in conjunction with the Eating Disorder Centre Cork (EDCC) through the Community Academic Research Links (CARL) initiative, it was the aim of this research design to carry out further research on this pilot study.

The aim of this research is to explore GPs knowledge of and experience with eating disorders in their practice, as well as the perceived challenges they could encounter when they may be presented with an eating disorder case, or a suspected eating disorder. It is the intention of the researcher to investigate this topic through the use of semi-structured interviews which are qualitative in nature. Through a process of semi-structured interviews within a qualitative methodology, the aim of this research project is to develop a more in depth understanding of the factors that may prevent a GP from the early diagnosis of an eating disorder among their patients/clients.

This study is both timely and relevant as the prevalence of eating disorders in Ireland is steadily increasing, representing eighty deaths per annum and an estimated 200,000 people are suffering with an eating disorder in Ireland (The Department of Health and Children, 2006). Eating disorders are highly complex disorders that represent both a threat to the individual physically but also psychologically, therefore making them difficult to treat (O'Dea and Parsons, 2013). McDermott's pilot study in 2016 utilised quantitative surveys and one qualitative interview in order to explore GPs knowledge of eating disorders in cork city and county. McDermott's study, highlighted that a strong majority of GPs surveyed felt they didn't receive enough training on the topic of eating disorders (McDermott, 2016). This study was beneficial in highlighting that GPs aren't receiving enough training in eating disorders. However, this study had the intention of sourcing the aspects of eating disorders that GPs are struggling with that may affect the early identification of eating disorders.

As a result of a review of the available literature on the topic of eating disorders, a gap in the knowledge was identified and a hypothesis for this research has been drawn up. The hypothesis states that GPs have a may struggle identify the early prognosis of an eating disorder in their patients/clients. This research aims to identify the factors that may be involved in preventing GPs from the early identification of an eating disorder in their patients/clients.

The research found that there was a range of factors involved in the struggle to detect the early signs of an eating disorder in the primary care¹ setting. Five main themes were highlighted and will be discussed at length in the analysis and findings chapter of this report.

This research design was carried out in partnership with the Eating Disorder Centre Cork, through the CARL initiative. CARL is a community based research initiative that allows students to engage with Civil Society Organisations (CSOs). It allows the student to liaise with an organisation and carry out research for the community with extra support. A community based research approach is a significant feature of this research design and for this reason it will be discussed in depth in the Methodology chapter.

This research design employed a qualitative approach to data collection. It involved six semi-structured interviews with GPs in the geographical constraints of the Munster province. The methodology for this research will be discussed in depth in the methodology chapter of this research report.

¹ These services involve all of the health or social care services that you can find in your community. This often includes GPs, public

Chapter Two: A Review of the Current Literature on Eating Disorders

2.1: Introduction

This chapter provides a literature review on some of the issues relating to the diagnosis and treatment of eating disorders. The first section of this literature review focuses on the classification of eating disorders. The second section focuses on role of GPs and their vital contribution to the early intervention process and the third section explores the possible factors that make eating disorders so complex in nature. Considering this study is primarily qualitative in nature, the qualitative research literature would be of significant benefit to the researcher. However, for the purpose of getting a broad and well documented piece of research both qualitative and quantitative methods will be considered. For the purpose of this research design, it will be the intention of the researcher to focus on eating disorders exclusively, these involving Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED). This is not to side-line the significance of feeding disorders², however due to time constraints it was decided by the researcher to focus on the three most prevalent strands of eating disorders amongst a broad topic of eating disorders.

2.2: Classification of Eating Disorders

The topic of eating disorders is broad and peoples' understanding of eating disorders can vary. For this reason the researcher will define what is meant by eating disorders and the subgroups that are categorised under the term eating disorders. Bodywhys³, the Eating Disorder Association of Ireland, define eating disorders as complex psychological disorders that affect every aspect of a person's functioning (O'Dea and Parsons, 2013). The *Diagnostic and Statistical Manual of Mental Disorders* fifth edition (DSM 5), outlines the four main categories of eating disorders consisting of Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder. They also include the category of 'eating disorder not otherwise specified (EDNOS)'. This fourth category includes those variations of eating disorders that cannot be assigned a more specific diagnosis due to insufficient information (Hoek et al, 2003). A major goal of the

² This involves a person who may experience food disturbance to the point that they do not meet their appropriate nutritional and/or energy needs. This may be due to a lack of interest in eating or worries about the consequences of eating.

³ The national voluntary organisation supporting people affected by eating disorders.

DSM 5 was to reduce the category of Eating Disorder not Otherwise Specified (EDNOS) which was a category listed in the DSM4. This category has been documented as being heterogeneous and not well- defined yet it was the most common diagnosis in clinical and community samples of adolescents, accounting 80% of all eating disorder diagnosis (Hoek et al, 2003). This highlights the lack of information and knowledge about eating disorders within the general population as well as the medical professional community. This variation of eating disorders described can be seen as a significant development compared to that of the DSM4 which only specified two eating disorders; anorexia nervosa and bulimia nervosa. Furthermore, the DSM 5 has changed the chapter on eating disorders to include eating and feeding disorders. The feeding disorders include 'pica numeration disorder' and 'avoidant restrictive food intake disorder'. Since this research is focused on eating disorders, it will be the intention of the researcher to focus on eating disorders exclusively however the advancements made to the DSM V cannot be overlooked.

Anorexia nervosa has been known to be a particularly challenging strand of eating disorders because it is associated with an elevated suicide risk of around 12 per 100,000 of the population (American Psychiatric Association, 2013). It is characterised with the sustained and determined pursuit of weight loss. This is achieved through severe restriction of food intake and in many cases, adapting methods of laxative use and induced vomiting, causing the individual to lose a significant amount of body weight as well as facilitating their isolation from society (Fairburn and Harrison, 2003). Patients who suffer with Anorexia Nervosa have high mortality rates, moderate recovery rates and a substantial proportion of those diagnosed with Anorexia Nervosa remain chronically ill throughout their lifetime (Van Son et al, 2010).

Bulimia Nervosa is associated with recurrent episodes of binge eating, inappropriate compensatory behaviours with the aim to prevent weight gain. An individual suffering with Bulimia Nervosa may adapt techniques of fasting or excessive exercise (DSM V, 2013). Attempts to restrict food intake are punctuated by repeated binges of eating during which there is an adverse sense of loss of control and can be followed by self-induced vomiting or substance misuse (Fairburn and Harrison, 2003). This particular strand of eating disorders can be difficult to detect for both non-professionals as the person suffering may often be of average weight or in some vases overweight and for the health professionals who may not initially see anything physically wrong. Most people suffering with Bulimia Nervosa may be of normal body weight or in some cases overweight due to the frequent episodes of uncontrolled overeating (Fairburn and Harrison, 2003).

Binge Eating Disorder is another common strand of eating disorders. It is similar to bulimia nervosa in the fact that it is associated with recurrent episodes of binge eating, evidence of marked distress regarding binge eating and the occurrence of episodes of binge at least once a week over a period of at least three months (American Psychiatric Society, 2013). While both disorders share this similarity, they differ considerably however, in the fact that those suffering with Binge Eating Disorder will not attempt to eliminate the large amount of calories consumed from a binge episode (Fairburn and Harrison, 2003).

In sum, eating disorders have one of the highest mortality rates of all psychiatric illnesses. Eating disorders present a challenge to clinicians due to their complex nature, as their cause is elusive with social, psychological and biological processes all playing a role (Fairburn and Harrison, 2003). The prevalence of eating disorders in western societies however, is increasing and it is clear they are posing a major health risk to society due to the high mortality rate associated with them as well as their co-morbid nature (McDermott, 2016).

2.3: Models of Healthcare Adapted in the Irish Healthcare System

Fairburn and Harrison have stated that eating disorders have social, psychological and biological origins (Fairburn and Harrison, 2003). While this statement suggests a bio psychosocial⁴ approach to be taken by GPs, this is often not the case as the biomedical model⁵ is still dominant in healthcare settings. An area of concern that cannot be overlooked is the model of healthcare that is adapted by GPs in the Irish healthcare setting. It is necessary to evaluate the history of mental health in Ireland in order to understand how Irish society has arrived at its current model of healthcare and approaches to mental health in modern contexts.

Bracken (2011) argues that it is the medical model that is so deeply entrenched into medical learning that it is affecting the way in which mental health is approached today (Bracken, 2011). The approach that is still dominant in the world of western medicine is the biomedical approach which has been defined as, a conceptual model of illness that excludes psychological and social factors and includes only biological factors in an attempt to

⁴ A theoretical framework that posits that biological, psychological and social factors all play a significant role in human disease or illness and health rates than biology alone.

⁵ A conceptual model of illness that excludes psychological and social factors and focuses on the biological element only in an attempt to understand a person's illness.

understand a person's medical illness or disorder (medical dictionary). Eating disorders are multidimensional consisting of both social and psychological elements, as well as biological (Fairburn and Harrison, 2003). Cleary and Treacy (1997) argue that there is an unhealthy reliance on drugs and doctors in the Irish healthcare system, which is not an adequate method of treating eating disorders. It has been argued that the traditional medical paradigm has served to justify a paternalistic and hegemonic culture in mental health, granting power to medical professionals (Bracken, 2011).

The World Health Organisation defines health as a complete state of physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 2018). This broad and encompassing definition of health adapts a biopsychosocial approach to health which can be defined as a theoretical framework that posits that biological, psychological and social factors all play a significant role in human disease or illness and health rates than biology alone (Wade and Halligan, 2004). The approaches that GPs adapt may vary but it is of particular significance as the model that they adapt can influence how they approach their patients and shapes how their knowledge is organised (George and Engel, 1980).

The biomedical model is a dominant model and has continued to dominate many forms of healthcare including mental health, which was based upon a traditional power role between doctor and patient (Wade and Halligan, 2004). It is widely accepted that the DSM is also based on biomedical model, as it emphasises the physical aspects of eating disorders as opposed to the psychological disturbances that are a significant element of eating disorders. Former President of the American Psychiatric Association, who publish the DSM5, stated that any mental disorder is in its essence a biological process (Deacon, 2013). It has also been argued however, that the biomedical model does not adequately explain many forms of illness, mainly due to three commonly held assumptions including:

- All illnesses have a single underlying cause.
- Disease (pathology) is always the single cause.
- Removal of the disease will result in a return to health (Wade and Halligan, 2004).

The biomedical model remains built on the assumption that there is a direct dichotomy between health and illness, and that the patient can be returned to a state of wholeness through the use of medication. It does not account for social and psychological aspects or any other methods of treatment beside the use of medication which has become the fabric of their

education (George and Engel, 1980). Wade and Halligan (2004) argue that the model of biomedicine has been built on the idea that there is a mind-body dualism as organically stated by Descartes. Mental phenomena such as emotional disturbance or delusions were believed to be separate from as well as unrelated to other disturbances of bodily function in the nineteenth and twentieth century as biomedicine colonised health knowledge and popular imagination (Cleary and Treacy, 1997). The belief remained that all illnesses and symptoms would arise from an underlying abnormality within the body, usually the organs (Wade and Halligan, 2004). Researchers have yet to discover a single biological marker with sufficient sensitivity and specificity to reliably inform the diagnosis of any mental disorder (Deacon, 2013). Considering the hegemonic framework that biomedicine established, it is difficult to bring about the shift towards a biopsychosocial approach, which would benefit how mental health is diagnosed and treated. As eating disorders have been categorised as a co morbid disorder it is necessary for ED patients to be treated both physically and emotionally which would suggest the adaption of a biopsychosocial approach as opposed to medication alone.

There appears to be an over reliance on the diagnostic medical labels that are commonly used within the biomedical model. People become defined by the diagnostic label which can also increase the stigma in this area which is already of concern for those struggling with eating disorders. There is already a high level of deniability associated with eating disorders; therefore increasing the stigmas already associated with it by applying the diagnostic labels could marginalise them further reducing the chance that they may seek help. The biomedical model is dominant in the Irish healthcare system as well as in Irish policy documents but it could be argued that it is slowly being challenged and changed in policy documents such as a *Vision for Change (2006)*⁶. It is hoped that a biopsychosocial approach, as suggested in *A Vision for Change*, will create the conditions in which genuine partnerships are created between service users, carers and professionals can work together for better integration (Bracken, 2011). GPs are in a vital position for both the coordination and integration of services that can bring about this change, which could aid the vital process of early intervention of eating disorders, yet eating disorders still appear to straddle all medical fields-psychiatry, psychology, and biomedicine (The Irish Times, 2017).

⁶ A strategy document which sets out a plan for the delivery of mental health services in Ireland.

2.4 GP's Role in Relation to Eating Disorders:

While the DSM 5 along with many other resources define and outline the categories of eating disorders, studies consistently show that GPs remain largely ill-informed on the topic of eating disorders resulting in a lack of confidence when faced with ED cases. Mond et al (2010), carried out a study that examined the features of women with bulimic type eating disorders attending primary care in two smaller urban regions in the United States of America. This study highlights that although more than 80% of participants with an ED have sought advice or treatment from a primary care practitioner of general psychological distress only one third of ED patients had ever been asked about problems with eating by a primary care practitioner (Mond et al, 2010). This is thought to be due to the lack of eating disorder mental health literacy⁷ that is made available for both patients and GPs (Mond et al). Psychological problems are so generalised that it may not occur to the GP to consider eating related problems.

The vast majority of people with mental health difficulties will seek advice or guidance from their GP, as they act as gatekeepers into the health system. This fact is elevated for those suffering with an eating disorder as current literature shows that those suffering with an ED are more likely to visit their GP with issues related to eating disorders but not distinctly presenting with an eating disorder (Ogg and Millar, 1997). Mond et al (2010) further highlight this fact by stating that 80% of those suffering with an ED sought treatment from the GP with issues relating to an eating disorder, such as fatigue, joint pain and gastrointestinal problems (Mond et al, 2010). This highlights the significance of the role of GPs within the community and it is vital that they are well informed and feel confident diagnosing any problem they encounter, yet Mond et al (2010), highlight that only a small minority of bulimic type eating disorders are identified by a primary care practitioner, a form of eating disorders which is becoming more prevalent within western societies (McDermott, 2016).

Linville et al (2010) engaged in a mixed methods study that consisted of one hundred and eighty-three quantitative surveys and twelve qualitative interviews with medical providers in the Oregon area. This study sought to examine medical provider's eating disorder screening and intervention practices as well as their training needs, it was found that 78% of GPs reported that they had patients with an eating disorder who they were unsure of how to treat (Linville et al, 2010). This fact could suggest a lack of training on the topic of eating disorders for primary

⁷ Knowledge and beliefs about mental disorders which aid their recognition, management or prevention.

care practitioners. This was further highlighted by McDermott in 2016. The lack of training GPs felt they received about eating disorders is made evident in McDermott's (2016) study. This pilot study sought to explore GPs knowledge of eating disorders in the Cork County area. This quantitative study found that some GPs responded stating that despite their lack of training in the area of eating disorders, that they had an average confidence in diagnosing eating disorders (McDermott, 2016). However it could be argued that GPs only had an average confidence level in the diagnosis of eating disorders due to experience gained through practice. This is allowing for a possible gap of under diagnosis in eating disorders by those GPs who may have not gained as much experience over the years or those who have just began their practicing career, thus highlighting the need to introduce sufficient training in eating disorders in undergraduate programmes.

McDermott's (2016) pilot study highlighted that only 13.9% of seventy-three GPs responded that they had received some training in the area of eating disorders while none at all identified not having received a great deal of training. Only 44.4% of GPs that responded felt they had an average knowledge about symptoms of eating disorders reflecting that only 44.4 % had only an average confidence in terms of identifying an eating disorder. A strong majority of 75% of respondents felt that they needed more training in the area of eating disorders when asked what they thought they needed to improve (McDermott, 2016).

McDermott's pilot study in 2016 is proof of the lack of research done in the area of eating disorders in the primary care setting. The existing literature clearly highlights the lack of effective eating disorder intervention in the primary care setting. To combat this, a number of guidelines for the dissemination of best practice have been set up. The National institute for Clinical Excellence (NICE) for example, gives clear guidelines on eating disorders for GPs which aims to improve the process of early intervention and identification of eating disorders among their patients (NICE, 2017). Bodywhys Ireland, adapted a similar method publishing an information leaflet titled '*Eating Disorders a Guideline for General Practitioners*' online (O'Dea and Parsons, 2013). While these guidelines have been made widely available for all GPs and other health professionals to access in countries such as Australia (The Butterfly Foundation, 2010) , Ireland, America (National Eating Disorder Association-NEDA and the DSM5) and the UK (NICE), the uptake has been slow among professionals to engage with such resources (Currin et al, 2007). Time constraints and overburdening workload have been suggestions made as to why these guidelines are not being adhered to (Currin et al, 2007).

Studies have shown that primary care physicians do not routinely use published protocols or guidelines for the management of eating disorders and it has been shown that this is not because their practice already complies with the guidelines recommendations, but possibly due to lack of awareness about the guidelines and/or the sheer volume of guidelines being unrealistic for GPs to study in such short appointments (Currin et al, 2007). While the resources made widely available are seen as a significant improvement to the field of eating disorders, they will not be effective if they fail to be utilised. There appears to be a broadly held view that there are too many constraints such as, time and work-load facing GPs to be able to manage eating disorders within their practice and utilise the resources that are made available for them (Currin et al, 2007).

2.5: Time Constraints

Time constraints, such as short appointments with patients/clients due to heavy workload, appear as a recurring theme in all areas of the healthcare system in Ireland. However due to the high mortality rate associated with EDs, early intervention is crucial. While recovery is possible in ED cases, they often last a lifetime or can take a life (The Guardian, 2017). Studies such as, Schoemaker (1997) and Cadwallader et al (2016), have indicated that while outcomes for EDs can be negative, they can be improved through early intervention processes. As the primary care setting has been quoted as the most important setting for early detection, it places GPs in a vital role when dealing with ED cases (Cadwallader et al, 2016). However the hope for early intervention and identification of an eating disorder can be hindered by time constraints in the primary care setting. Screening for an eating disorder can be time consuming in comparison to other illnesses and disorders (Linville et al, 2010). GPs have stated that it can take numerous visits to build a rapport with their patient and there is pressure on them to diagnose and understand their condition in such a short space of time (Pentony, 2012). It has been argued that it is not possible to assess the needs of complex patients in a ten minute appointment as there is increased need for more investment and longer consultations in Britain (Siddique, 2016). The Irish context is not an exception to this problem as it cannot be denied that there is an often unrealistic expectations placed on GPs with the workload they face being placed in a gatekeeper role to all secondary healthcare in the Irish context, which may present as a hindrance in the early identification process of an eating disorder. The recurring issue of time constraints extend beyond that of primary care as access to secondary care services are becoming more difficult. In the Irish context, GPs are struggling to refer patients to the HSE's

Child and Adult Mental Health Services (CAMHS), as it has been documented that there can often be a waiting list of six to twelve months (The Irish Times, 2017).

2.6: The Challenging ED Patient/Client

Previous studies on the area of eating disorders have stated that ED patients have been stereotyped as challenging to communicate with (Pentony, 2012). This can be due to number of reasons including the high mortality rates, their health status, high relapse rates, they are highly co-morbid in nature, the association with impaired cognitive thought as well as a difficulty in maintaining a therapeutic relationship (Pentony, 2012). Due to these inherent difficulties it has been argued that many healthcare professionals avoid working with ED patients (Linville et al, 2010). A recurring theme in ED studies is the high of deniability that the ED patient practices. Most ED patients will deny having an eating disorders and will go to considerable lengths to hide it, with some even believing that they don't have an eating disorder. Individuals may hide their symptoms or it can be buried beneath the psychiatric morbidity which can be frustrating for the GP. This affects the rapport building process thus, can contribute to a hostile environment which is not an idealistic for the intervention and detection process (Pentony, 2012). It has also been stated that GPs felt the need to motivate their patients which can be frustrating, time consuming and exhaustive work. Healthcare professionals have reported feeling sadness and disappointment at the patients who lack motivation to recover (Linville et al, 2010).

2.7: Stigmatising and Stereotypical Views towards ED Patients

It has been stated that since GPs are in contact with patients at an early stage of their illness, they need to diagnose them at the earliest stage possible for improved outcomes (Cadwallader et al, 2016). This is a difficult process however, due to the complex nature of eating disorders and it is further hindered by the stereotypical and stigmatising views that are widely accepted about those struggling with an eating disorder. Doctor Sara McDevitt from the College of Psychiatrists stated that eating disorders are the most stigmatised mental health issues, with a strong majority of Irish society often failing to equate eating disorders with mental health issues (The Irish Times, 2017). Some professionals felt that the responsibility lay within the patient's lifestyle and attitudes. McNicholas et al (2016), carried out a recent study which examined aspects of healthcare professionals' knowledge and attitudes about eating disorders which might improve direction of treatment of EDs in Ireland. It was found

that stigma and stereotypes influence Health care professionals' clinical and interpersonal interactions, which has a negative impact on the ED patient's engagement with the healthcare services (McNicholas et al, 2016). The research shows that social stigma surrounding EDs is a major barrier to seeking help for those suffering with an ED, however it also has a negative impact on the GPs perceptions about ED patients. Specifically compared with other mental and physical illnesses, EDs are often seen as self-inflicted or as an attention seeking mechanism by both society in general and by GPs (McNicholas et al, 2016). GPs are not immune to these social stigmas that are prominent within society, and data has revealed indications that healthcare professionals hold more negative attitudes towards ED patients relative to other mental or physical illnesses (McNicholas et al, 2016). Attitudes such as notions that EDs are self-inflicted or that they have a high level of control over their condition can hinder the early identification process and the ability of the patient to engage in the healthcare services. Healthcare services should cultivate an awareness of how professionals attitudes can impact on service quality and of the detrimental effect stigma consciousness can have on people's decision to initiate and maintain treatment (McNicholas et al, 2016).

2.8: The importance of Early Intervention in Eating Disorders

There is evidence to suggest that factors such as time constraints, stigma, and the difficulty involved in eating disorder cases all play a part in hindering the early identification process of eating disorders. It has been reported that an estimated four hundred new cases of eating disorders emerge each year in Ireland, representing eighty deaths annually. In 2016, eating disorders were the second highest child and adolescent admission diagnosis at twelve percent of all admissions (Department of Health and Children, 2006). This shows the pressing concern eating disorders are posing to Irish society and the need for early intervention and detection of an eating disorder within an individual. However studies have shown that there is a lack of early intervention and identification strategies within the primary care setting. It is the intention of the researcher to explore why this may be the case in what follows.

Currin et al (2007), highlight that there may be unrealistic expectations placed upon GPs that might result in the deduction that treatment for eating disorder patients is outside the primary care remit (Currin et al, 2007). However studies consistently show that the most effective treatment approaches occur in the primary care setting and is also the most cost

effective for the state and society (Shoemaker, 1997). This highlights the importance of GPs in the early intervention and identification process of eating disorders among their patients. Previous studies have stated that early intervention is a vital prognostic factor in the treatment of anorexia nervosa, and that a large interval between the time of onset and first admission for treatment has a negative impact on the outcome of effective treatment (Shoemaker, 1997). The need for early intervention in any form of healthcare issue is important, however it has been argued that it is even more vital in the case of eating disorders as they are associated with high mortality rates and are susceptible to relapse cases. Previous studies have stated that GPs have highlighted that patients often do not present with eating disorder problems until a crisis, such as being admitted to Accident and Emergency or hospital, has occurred (McDermott, 2016). This further highlights the need for early intervention in the identification process of eating disorders.

Hoek and van Hoeken (2003), carried out a review on the prevalence and incidence of eating disorders and they confirmed that patients who suffer from anorexia nervosa have a high mortality rate, moderate recovery rate and a substantial proportion of the patients remain chronically ill (Van Son et al, 2010).

The benefits of early intervention is also highlighted in Schoemaker's 1997. This study involved an extensive search in literature concerning treatment outcomes for AN sufferers in Holland, Germany and England, specially addressing the prognostic value of the duration of illness (Schoemaker, 1997). This study found that early detection and referral to specialist care means that the disorder will be treated at a less advanced stage thus improving the chances of recovery while decreasing overall mortality rates (Schoemaker, 1997). Within this statement another issue is presented which GPs face, and that is their knowledge of the specialised services available to those with eating disorders.

Studies have shown that GPs who have practices in the same area of a specialist eating disorder service have a better understanding of eating disorders and feel more confident diagnosing a patient with an eating disorder, as they feel there is more support available to them (Currin et al, 2007). McDermott's (2016) study also highlighted the need for access to more specialist services as requested by GPs in order to improve their own practice, as a result of 63.9% of GPs being unaware of specialist services available for eating disorders (McDermott, 2016). While it may not be feasible to have a broad range of specialist services throughout Ireland, there appears to be a need to extend the services beyond the Dublin based

location⁸, to allow for more efficiency in treating eating disorders. There appears to be a lack of integration and coordination between the primary care setting and the specialist services within the healthcare setting in Ireland leading to inefficiencies in the problem of eating disorders. Early detection and referral to specialised care means that the disorder will be treated at a less advanced state thus improving the chances of recovery while decreasing overall mortality rates of Anorexia Nervosa and other types of Eating Disorders (Van Hoeken et al, 2010). It has to be acknowledged that mental health providers and medical providers roles can often be confused resulting in back and forth referrals however this issue needs to be addressed to allow for better coordination and delivery of services (Linville et al, 2010).

2.9: Conclusion

The review of the literature surrounding eating disorders suggests that there are numerous difficulties facing GPs when working with an eating disorder patient/client. These challenges can include issues such as time constraints, attitude and beliefs that the GP may have previously held, the high co-morbidity associated with the eating disorder condition and lack of support being expressed for GPs. All of these challenges could present as a barrier to the early identification and intervention process of Eating disorders. It is the intention of the researcher to focus on these themes throughout the research design.

⁸ Services for eating disorders in Dublin include:

1. The Sandyford Wellness Centre offering support groups and therapy.
2. St. Patricks Hospital, who provide a comprehensive eating disorder programme.
3. Lois Bridges who run an outpatient and inpatient facility for those struggling with an eating disorder.
4. Lucena Centre Services who provide mental health services for children and adults throughout Ireland but are based in Dublin.

Chapter Two: A Review of Current Policy in relation to Mental Health

2.10: Introduction

The aim of this chapter is to review the current policies that are being implemented, both nationally and internationally, in relation to eating disorders. It has been noted that policies related specifically to eating disorders have been lacking both nationally and internationally. For this reason, much of the policy implications that exist on eating disorders, come under the umbrella term of mental health policy. For this reason, the majority of the policies that will be discussed in this chapter are centred on mental health policy.

2.11: Irish Mental Health Policy

Eating disorders fall into the category of healthcare and more specifically mental health care, a subject which receives a lot of criticism within the Irish context, and the subject of eating disorders isn't an exception. Health is one of the most contested and debated areas of social policy in Ireland, arguably because of its unique system of organisation (Dukelow and Considine, 2017). Dukelow and Considine (2017) highlight the three main models of healthcare systems. These include a national health system, a social health insurance system and a private health insurance system. Ireland has a unique healthcare system as it doesn't fall strictly into any category instead practising a mixed system of healthcare containing both elements of a national health system and a private health system (Dukelow and Considine, 2017). Another unique feature to the Irish system is the entangled relationship between the public and private insurance which results in a substantial amount of private care being delivered within the public system which produces many inequalities and inefficiencies which is translated onto policy development and implications.

During the 1950s the level of institutionalisation in Ireland was at its highest internationally, with a rate of 710.34 beds per 100, 000 (Higgins, 2014). It is therefore surprising that with such a strong history of mental health, whether legitimate or not, that there still remains a lack of policy implementation and legislation around the subject of mental health in Ireland.

It has been argued that the efficiency of a country's social policy is best judged in times of recession. In the Irish context, a policy of retrenchment was adapted by the Irish government. This meant the reduction of governmental funding to all areas of welfare. This system proved to be inefficient and showed up the inadequacies of the healthcare system. The healthcare system was the area most affected with cutbacks in public healthcare leading to more private and out of pocket healthcare. The policy of retrenchment involved reducing staff numbers shortening hospital stays and reducing public hospital bed capacity (Dukelow and Considine, 2017). These cutbacks put further strain on the already controversial two tier healthcare system, as public patients experienced growing waiting times for care, which can potentially be fatal for those service users struggling with an eating disorder. Policy developments since the 1990s have included two overall strategic plans, numerous reports dealing with issues of funding, staffing and organisational change and several more reports dealing with issues of reorientation of the healthcare services and addressing contemporary health issues such as eating disorders, however Ireland has yet to introduce any policy document that addresses eating disorders exclusively. While *A Vision for Change (2006)* designates a section of the policy document to eating disorders (see pages 149-154) many of the strategies have yet to be addressed. There appears to be a general malaise within the Irish healthcare system in respect of the structures, performances and policy implementation within the healthcare system. Prioritising financial control in the context of under resourced services and to the detriment of other health policy goals such as access and equity is problematic. Five years of persistent cuts to the healthcare budget and staffing numbers has showed up in the efficiencies of the healthcare system in Ireland to the detriment of service users and the greater community, this can be witnessed in the lack of effective policy implementation particularly around mental health care.

The introduction of the *Mental Health Act 2001*⁹, the establishment of the Mental Health Commission and the publication of *A Vision for Change* in 2006, appeared to indicate that Ireland might be coming of an age in respect of its approach to Mental Health issues as well as its delivery of mental health services. However while these changes can be seen as a positive development in Irish social policy, the history of brutality and institutionalisation that defined mental health services in Ireland cannot be overlooked. The history of mental health

⁹ An Act to provide for the involuntary admission to approved centres of persons suffering from mental disorders.

acts in Ireland consisted of the *Criminal Lunatics Act 1800*¹⁰, *The Lunatic Asylums Act 1821*¹¹, and *The Dangerous Lunatics Act 1843*¹² all of which adhered to the period of great confinement¹³(Goffman, 1968). They followed the *1834 Poor Law*¹⁴ which categorised a person as deserving or undeserving creating a stereotype of a person with mental health difficulties as being ‘othered’ with the need to be separated from society and confined in an asylum. This method of separation or confinement initiated mental health as a taboo subject, an idea which has been adapted into society today, wherein there appears to be the same idea that mental health is a taboo subject. In a study of over two thousand participants across Britain, it was found that 30% would find it difficult to publicly admit to having a mental health issue of some sort. As well as this it was reported that fewer than four in ten employers would feel able to employ someone with a mental health difficulty (O’Hara, 2009). This study is less than ten years old, highlighting the fact that topic of mental health is still looked upon on a taboo subject in modern day contexts.

The twentieth century brought to light some of developments within the mental health field as most western states adapted a method of integration as opposed to separation. Mental health services became slowly integrated into mainstream health services, however it was a slow process and many were slow to abandon the view of those struggling with their mental health as dangerous lunatics leading to stereotypes that we would like to believe have been long forgotten yet still impinge on our perceptions as well as how we talk, treat and address mental health issues today.

The period of asylums and confinement has slowly been replaced by a dominant biomedical model. The institutional arrangement and increasing use of a system of categorisation of insanity facilitated the rise of medical control over the rise of mental distress. The legacy of medical control over mental health issues continues to have a strong influence on practice to this day. While *A Vision for Change (2006)* promotes a biopsychosocial approach

¹⁰ An Act that established set procedures for the indefinite detention of mentally ill offenders.

¹¹ An Act to make more effectual provision for the establishment of asylums for the lunatic poor and for the custody of insane persons charged with offences in Ireland.

¹² An Act to make provision for the safe custody of and prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind.

¹³ A period of excessive confinement in asylums and the excessive use of detention in institutions as a form of moral control.

¹⁴ An Act that ensured that the poor were housed in workhouses, clothed and fed. In return for this care the poor were expected to work long hours every day.

to mental health in Ireland, it is evident that Irish society still abide strictly by the biomedical model, this places those in the medical profession in a critical role. Those working in healthcare system need adequate training and provision within the field of mental health as well as physical health. Mental health issues and its related conditions such as eating disorders have been classified as relatively new conditions. As a result of this it may be difficult for GPs and those within the medical field to feel experienced in the area, however it has been stated that eating disorders are among the most fatal of all mental health conditions (Health and Child Department, 2006) so it is therefore vital that policy provisions support this. Ireland's lack of policies surrounding eating disorders shows up the inefficiencies in the healthcare system.

2.12: Irish Policies on Eating Disorders- A Vision for Change

The *Vision for Change* document describes a framework for building and fostering positive mental health across the entire community and for providing accessible community based specialist services for people with a mental illness. *A Vision for Change* (Department of Health and Children, 2006) cannot be overlooked in its positive approach to mental health service delivery and provision in Ireland, eating disorders have fallen into the category of mental health and this is a topic in Ireland that is still relatively new as society tries to abandon previously held views of mental health difficulties as a form of lunacy, which it has been successful in achieving as service users voices are being valued and accepted in society. The strand of mental health that results in eating disorders is a newer concept again, so for Ireland to have a document such as *A Vision for Change (2006)*, which addresses the need to have policy supports around eating disorders is significant. It identifies the three most common forms of eating disorders; anorexia nervosa, bulimia nervosa and binge eating. As well as that it raises an awareness of the seriousness of eating disorders and the impact they are having on Irish society which had been previously overlooked (Department of Health and Children, 2006). It raises the alert of the seriousness of eating disorders through succinct statistics and facts estimating that those struggling with an eating disorder in Ireland currently stands at 200,000, with a mortality rate of 20%. The epidemiological evidence is accounted for stating that there is an annual incidence of ten cases of anorexia nervosa per 100,000 of the population for females and 0.5 for males in the Irish context (Department of Health and Children, 2006).

Another important aspect of this key policy document is its effectiveness in highlighting the downfalls of current policy provision in the Irish system. Ireland did not and still does not have

an effective method of dealing with the issue of eating disorders. When the document was published in 2006, Ireland only had three designated specialist beds for the treatment of eating disorders in the public mental health service and two eight bed units in the private sector (Department of Health and Children, 2006). This outlines the inadequate service provision that exists with the Irish healthcare system and reiterates the view that financial control is prioritised in the context of under resourced services to the detriment of other health policy goals such as access and equity (Dukelow and Considine, 2017). The services for those struggling with an eating disorder are exclusionary as the document states that the private sector is better catered for than the public sector, resulting in a situation where public patients are paying for their own subordination, yet being marginalised further. The majority of the specialised services are in a Dublin based location which does not meet the demands of the country as a whole.

A key aspect of *A Vision for Change (2006)* is the topic of mental health in primary care. The document highlights the need for better integration and coordination of mental health services including the primary care setting, specialist mental health settings and the voluntary organisations that specialise in mental health. The advisory group believed that these services should be enhanced and formalised to deliver an inclusive and well-rounded effective service. However the emphasis still remains on the primary care setting, as 90% of mental health difficulties are dealt with in the primary care setting without referral to a specialist mental health service (Mental Health Reform, 2015). This positions GPs in a gatekeeper key role to the mental health services, yet studies have shown that many GPs feel that the supports are not widely available to them or that they do not have sufficient evidence about them (McDermott, 2016).

To combat this issue, '*A Vision for Change*' (2006) contained a number of recommendations to enhance the capacity of primary care workers to address the mental health needs of the population. These recommendations included:

1. Delivery of appropriate mental health training among GPs across the country, as well as those in undergraduate medical programmes.
2. Implementation of the consultation/ liaison model to ensure effective communication between primary care and specialist mental health services.
3. The introduction of a range of incentive schemes to ensure mental health issues can be addressed in the primary care setting (Mental Health Reform, 2015).

While these recommendations sound promising, it is now twelve years on since the publication of *A Vision for Change* and Irish society has yet to see some of these recommendations implemented in policy. The strategic document highlights the need to adapt a biopsychosocial approach to mental health services, as well as the need to include service users in the delivery of their care plan. However the implementation of this policy document remains a significant concern. Staffing levels in 2015 were approximately 75% of what was recommended in *A Vision for Change*, nearly ten years into the plan (Dukelow and Considine, 2017). Other shortcomings of the document can be seen in the inadequate out of hour's services, the inappropriate placement of children in adult facilities and the lack of a right to an advocate. This key policy document has failed to address these crucial issues (Dukelow and Considine, 2017). Due to the policy of retrenchment adapted by the Irish state during the recession, healthcare services remain understaffed and underfunded. The mental health sector is not an exception to this issue and funding and staffing present as one of the main barriers to progress in this sector. Without the means to improve such services it is difficult to see how the future of mental health policy can be improved.

Due to the lack of efficient mental health care policy in the Irish healthcare system, a significant amount of pressure is placed on the voluntary sector. While it is true that Ireland experiences a mixed economy of welfare¹⁵, the voluntary sector are experiencing an increased burden of healthcare, due to the shortcomings of the public healthcare sector (Dukelow and Considine, 2017). It was recommended in *A Vision for Change* that there would be a shift from institutionalised care to more community based settings (Child and Health Department, 2006). This shift from institutionalised care to community based care came about after the publication of the *Planning for the Future* policy in 1984. Since the publication of this policy the general trend in the pattern of admissions to psychiatric facilities in Ireland has seen a significant reduction in the number of admissions to public psychiatric hospitals and a greater reliance on community based care (O'Shea and Kennelly, 2008). However significant gaps still exist with respect to community based provision and there continues to be a lack of integration of service provision and coordination in the Irish healthcare system. In the absence of statutory provision, voluntary groups have often been forced to fill these gaps (O'Shea and Kennelly, 2008). Voluntary organisations such as Bodywhys, Reachout, Mental Health Ireland, and Eating

¹⁵ A state wherein private, voluntary and informal sectors all contribute to the delivery of healthcare.

Disorder Hope have been forced to provide many of the services that aren't being provided through the public health system in Ireland.

2.13: International Policy

While this research design is based on the Irish context it is useful to compare Irish policy on a global scale, to grasp a better insight into the effectiveness of Irish policy in relation to other countries. When critically analysing any social policy it is often critiqued against other countries providing us with a benchmark with which standards are set and goals created.

Eating disorders fall into the category of mental health care, however mental health is a broad concept and its level of policy provision varies in every country. Therefore it can be difficult to find policies that concern eating disorders exclusively and many countries such as Ireland do not have any individual policy for eating disorders, yet they have institutions that prove invaluable in providing a platform for the future development of eating disorder policies, prevention and treatment. One such organisation is the Academy of Eating Disorders. They are a global association committed to leadership in eating disorders research, education, treatment and prevention. Their aim is to provide a platform for the promotion of understanding, sharing of knowledge and research practice integration.

A Vision for Change highlights the need to better coordinate services between primary care, specialist healthcare services and voluntary groups that are specialising in mental health promotion (Child and Health Department, 2006). This is reiterated on an international level in the World Health Organisation's (WHO) publication *'Mental Health: New Understanding, New Hope'* (2001). It highlights the crucial role that primary healthcare plays in mental healthcare yet that many mental disorders are often not detected within the primary care setting (WHO, 2001). The report acknowledges that GPs and other primary care workers are placed in a difficult situation in that the majority of their training is focused on physical health and symptoms. Mental health is a difficult topic to approach due to its high level of co-morbidity. Many of those service users struggling with their mental health will visit their GP presenting with physical symptoms which are often due to underlying mental health issue (WHO, 2001). To combat these issues the report recommends that GPs should be trained in the detection and treatment of common mental and behavioural disorders. This recommendation is supported by the evidence that some African, Asian and Latin American countries show that adequate

training of primary care healthcare workers in early recognition and management of mental disorders can improve the mental health of service users (WHO, 2001).

2.14: Eating disorders in UK

Like many healthcare systems throughout the world, there are both positives and negatives to the UK's healthcare policy on eating disorders. Their mental health legislation allows for the service user to undergo treatment without their consent and can be invoked if an eating disorder patient was refusing treatment (Eating Disorders, 2007). This can be seen as a negative aspect of their healthcare policy as it seems to be denying a person with mental health issues their autonomous rights. However it could also be argued from the lens that eating disorders are associated with a large mortality rate and the healthcare system try to adapt any means possible to save lives. This again highlights the importance of GP's and their role in early intervention and identification. An eating disorder should never have to escalate to a level that leaves little or no options but to intervene against a patient's consent. To combat this as well as to improve GPs knowledge and awareness The National Institution of Centreal Excellence (NICE), was established, which is a positive aspect of the UK's healthcare policy towards eating disorders. NICE commissioned a set of guidelines covering the treatment of eating disorders in adults and in children over the age of eight years of age. This is a broad and encompassing age group catering for all of society struggling with an eating disorder. NICE acknowledges the important role of the GP within any healthcare setting as they are the gatekeepers to any healthcare service. They aim to improve and build upon GPs awareness and knowledge base. NICE introduced an implementation support programme which includes initiatives for improving GP awareness. They also set up informal consultation guidelines between GPs and specialist due to the fact that GPs in areas where there are specialist services are shown to be better informed (NICE, 2017). However under 4% of GPs report using any guidelines at all for the eating disorders (Currin et al, 2007).

Eating disorders present as a significant public health issue that urgently needs to be tackled yet America remains somewhat behind other countries such as Australia in terms of policy implications around eating disorders. It is a public health burden that puts further strain on an already under-resourced healthcare system in America. While legal initiatives related to eating disorders have thus been limited there has been some initiatives taken to act against the issue of eating disorders in the United States.

There has been a push by advocacy organisations to introduce the Federal Response to Eliminate Eating Disorders Act (FREED act) in congress. This would provide funding for research education and prevention activities as well as improve access to treatment of eating disorders by requiring treatment coverage to be consistent with coverage of medical benefits (Puhl et al, 2014). Certain states within America have also made efforts to tackle the growing issue of eating disorders. Virginia required schools to promote early detection of eating disorders in youth in 2013, and California made it a misdemeanour for coaches to distribute laxatives for the purpose of weight loss to youth athletes (Puhl et al, 2014). While these advancements signal a positive change in policy implications around eating disorders there is still a lack of general policy for the country as a whole, therefore resulting in a lack of legitimacy.

Australia's healthcare policy towards eating disorders is arguably more comprehensive and significantly more advanced than that of other countries. The National Eating Disorders Collaboration (NEDC), produced a national framework document in 2010 that was focused solely on eating disorders. There are policy documents around the world that include sections on eating disorders, such as *A Vision for Change (2006)* in Ireland and the *FREED Act* in the US. However there is none besides Australia that have a policy framework on eating disorders exclusively. The National Eating Disorders Collaboration is led by the Butterfly Foundation which is a foundation that supports Australians with eating disorders. In a joint collaboration the Butterfly Foundation and the National Eating disorders collaboration produced 'Eating Disorders the Way Forward'. This strategic document aims to address eating disorders in all their forms as well as to identify what is known and what is not known about eating disorders in an effort to progress in the future and to better inform society as a whole about eating disorders (NEDC, 2010).

The vision of this document is for eating disorders to be treated as a priority mainstream health issue in Australia, where the topic has been side-lined against other mental health issues in many other countries. They NEDC wish for every Australian at risk of developing an eating disorder, to have access to an effective continuum of eating disorders prevention, treatment, care and ongoing recovery support (NEDC, 2010). The document is detailed and provides a broad depth of knowledge on eating disorders, including commonly held misconceptions about eating disorders. These include mistaken beliefs that eating disorders are about vanity, a dieting

attempt gone wrong, a cry for attention or a passing phase. The NEDC youth consultation identified that 51.3% of 12-17 year olds strongly agreed or agreed that a person with an eating disorders should 'shape out of it' (NEDC, 2010). The NEDC highlight the significant threat these misconceptions pose to those struggling with an eating disorder, affecting the responses and explanations sufferers receive when they present for help from GPs. This leads to a failure to detect and treat these serious illnesses as well as causing great distress to the individuals in desperate need of help.

The overall aim of this document is prevention. It promotes awareness of the issues of eating disorders in Australia and tries to foster a better integrated plan to not only aid the knowledge of healthcare professionals, such as GPs, but also the knowledge and commonly held misconceptions that exist within society (NEDC, 2010). The NEDC state how the eating disorders are the 12th leading cause of mental health hospitalisation within Australia and the expense of treatment of an episode of anorexia nervosa has been reported to come second only to the cost of cardiac artery bypass surgery in private care (NEDC, 2010). In this Irish context, eating disorders were the second highest child and adolescent admission diagnosis, at 12% of all admissions (Bodywhys, 2017). While these facts cannot be generalised to a global scale it cannot be denied that eating disorders pose a significant risk to the sustainability of the healthcare system in every country. The average duration of an eating disorder is 3-7 years (NEDC, 2010). There is already a high number of Irish individuals traveling to the United Kingdom for treatment of eating disorders all causing a further burden of finance on the Irish government. In establishing the national eating disorders collaboration the commonwealth government has provided for an opportunity for collaboration, development, from the Australian model of prevention should be something that is translated to a global scale.

2.14: Conclusion of policy review chapter

Recent years have seen crucial progress in our collective ability to be more open about mental health issues. However this has been largely led by individuals and advocacy groups, while state provided mental health services remain under-resourced and in need of major investment and reform (Dukelow and Considine, 2017). The prevalence and health consequences of eating disorders have prompted increasing discussion of potential policy actions to address the increasing public health burden. However while there is significant amount of media attention and discussion circulating around the subject of eating disorders

there still remains a lack of global initiative to tackle the issue. The researcher has highlighted the lack thereof effective policy documents on eating disorders exclusively on both a national and international level. Early diagnosis and intervention can reduce this duration significant however Ireland don't take the necessary steps to better inform the healthcare sector and society as a whole then the probability of an early diagnosis will continue to be reduced. There is increasing calls for government policy actions to help reduce and prevent these problems on a broader scale yet there still remains a lack of integrated progress on the global issue.

Chapter 3-Methodology

3.1: Introduction

The aim of this chapter is to outline the methodological approach of this research. It will give a description of the semi-structured style interview that the researcher used when carrying out all relevant fieldwork and it will also look at the advantages and disadvantages associated with using the qualitative approach. It also highlights how the research participants were sourced by discussing the method of sampling used as well as the ethical implications that were necessary to consider throughout the process. As mentioned previously in this study, this research project was carried out in conjunction with the Eating Disorder Centre Cork (EDCC), through the CARL initiative, making this a community based research project. As this was a significant feature of this research design it is the intention of the researcher to discuss community based research in this chapter.

3.2: A qualitative approach

A significant aspect of this research design is the decision to carry out fieldwork research as opposed to desktop research making the research report primary in nature as opposed to secondary research. This research design utilises semi-structured interviews with GPs, making it of a qualitative nature, as opposed to quantitative.

Qualitative research is a research strategy that usually emphasizes words rather than quantification in the collection and analysis of data (Bryman, 2012). The primary aim of qualitative research is to generate data which gives an authentic insight into people's experiences (Silverman, 1998). Silverman (1998) argues that those who aim to understand and document others' understandings choose qualitative interviewing as it provides us with a means for exploring the points of view of our research subjects). The main objective of this research design is to gain further insight into what factors can prevent a GP from the making an early identification of an eating disorder. It was, therefore necessary to explore the GP's point of view through the use of semi structured qualitative interviews, as they are a source of well grounded, rich descriptive information, that help to grasp a more in depth, well rounded explanation of the factors that may be involved in the delaying the early identification process of eating disorders. A qualitative approach was chosen by both the researcher and the EDCC clinical coordinator. The qualitative approach was chosen over the survey method as this research design is based on a pilot study of GPs knowledge on eating disorders (McDermott, 2016). This pilot study consisted of a survey based approach, so it was therefore decided that

a qualitative style would be best suited as a follow on approach from the original quantitative approach used in the pilot study in 2016.

3.3: Features of qualitative data

Bryman (2012) highlights that there are a number of features common to qualitative data. He argues that qualitative data is an inductive¹⁶ view of the relationship between theory and research whereby the former is generated out of the latter. It is interpretivist, the stress is on understanding the social world through an examination of the interpretation of that world by its participants. It is also an ontological position described as constructivist, which implies that social properties are outcomes of the interactions between individuals, rather than phenomena and separate from those involved in its construction.

3.4: Data Collection and Analysis

3.4.1: Sampling

In order to gather a number of research participants a method of sampling had to be utilised. For the purpose of this study it was decided by the researcher along with the supervisor from UCC and CARL to use purposeful sampling. This involves the idea that research ideas and/or questions are likely to produce guidelines as to what categories of people need to be the focus of attention and therefore sampled (Bryman, 2012). Purposive sampling is a non-probability form of sampling, therefore it is not on a random basis. Its goal is to sample people on a strategic basis, this does not allow them to be generalised. While this has been noted as a disadvantage and a possible limitation to the study, it was the decision of the researcher that it would be most beneficial to use purposive sampling in order to achieve the most accurate results. As this study attempts to investigate what can prevent a GP from the early identification of an eating disorder, the most appropriate group of research participants would be GPs. This research design also involved convenient sampling, as the researcher conducted interviews with those GPs who responded agreeing to engage in the research. The use of purposeful and convenient sampling in locating GPs to participate in the study was aided by the involvement of Community Academic Research Links (CARL), who acted as another support to the researcher throughout the duration of this study.

¹⁶ Involves the search for patterns from observation and the development of explanations/theories for those patterns through series of hypothesis.

3.42: The semi-structured interview

This research was conducted using semi-structured interviews, which can be defined as ‘a context in which the interviewer has a series of questions that are in the general form of an interview schedule but is able to vary the sequence of questions’ (Bryman, 2012: 159). Due to the interpretive nature of this research design and the largely exploratory element of the research, it was decided to utilise the semi-structured style of interview as the interviewer usually has some latitude to ask further questions in response to what are seen as significant replies. Due to time constraints it was decided to engage in six interviews with six different GPs in the Munster area, of varying ages and gender, using a semi- structured approach for each interview. However due to time constraints of the researcher as well as the GPs, only four GPs were interviewed for the purpose of this research. The researcher felt it was necessary to consult with the clinical coordinator of the EDCC in order to devise an interview schedule and discuss the questions that may be asked of GPs. The researcher felt this meeting was necessary in order to grasp further insight into the types of questions that would be most appropriate to ask GPs In order to adequately answer the research question. As the clinical coordinator of the EDCC, it was felt that she would have more experience in the area, and as this is a CARL project the researcher decided to utilise the supports that are provided through this community organisation. It was the combination of support from the EDCC clinical coordinator as well as the evidence found in the literature that founded the basis of the semi-structured interview questions.

3.43: The Interviews

Due to this research project being carried out in conjunction with CARL there was greater ease of access to research participants as well as support in the formulation of questions for the purpose of the interview. As this research involves a small scale study of Munster based GPs, it was necessary to select 4-6 Munster based GPs. The process of identifying GPs to partake in the research was completed by both convenient and purposeful sampling. GPs were located by selecting names randomly from a list of registered GPs in the Munster area. This list was on the Health Service Executive website and well as the Irish College of General Practitioners website, which included emails and phone numbers allowing ease of access to contact. The researcher experienced considerably difficulty in accessing GPs to agree to partake in the research. This could be due to their own workload and time constraints. For this

reason, the research felt it was necessary to consult with the clinical coordinator of the EDCC as well as the researcher's supervisor where it was decided to consider email or phone interviews. However the researcher found this attempt unsuccessful, and although interviews with 4 GPs were eventually sourced it was an issue for the researcher with the timeframe that is applied to an undergraduate thesis. In order to best accommodate the GPs that agreed to participate in the research, the researcher agreed to conduct the interviews at each of the GPs practices.

3.44: Analysis

The process of data collection and analysis involved presenting the large amount of qualitative data gathered into a more clear and concise interpretation. The researcher used an inductive approach when analysing the data received. Qualitative data analysis is largely inductive as well as interpretive. It generally proceeds inductively from making specific observations to identifying recurring themes and patterns in the data. The researcher was cautious during this process so as to avoid the issue of selective anecdotalism or selecting the statements that support a particular argument, which have been ethical concerns associated with qualitative data (Life, 1994). In order to combat this issue the researcher has identified and stated these themes below, through the process of thematic analysis. The inductive approach varies considerably from the deductive approach which is generally used in quantitative data. This process involves taking specific numerical or categorical responses to closed-ended questions based on variables that reflect theoretical constructs and analyse the data collected using statistical procedures (Forman et al, 2008).

The researcher transcribed all interviews to allow for the greatest level of transparency, reliability and validity. This process was possible due to the researcher's decision to record the interviews on two separate devices, which the researcher then stored on a hard drive and listened to repeatedly, while transcribing. This is vital in the research process as transparency is a basic requirement, allowing the reader the opportunity to peer into the processes involved in the data collection and analysis (Life, 1994). Once the interviews were transcribed the researcher presented the findings in a report which are then discussed in the conclusion of the research report. This process was achieved through the use of thematic analysis, which is the process of identifying recurring themes and patterns from the interview recordings. The

thematic analysis yielded to five main themes which include; GPs knowledge of eating disorders, time constraints, Integration of services, The challenging ED patient and Stigma.

3.45: Advantages of the interview

It has been stated that qualitative research aims to carry out its study in a calm relaxed environment so that the information is gathered by talking to people directly and observing their body language and reactions (Creswell, 2015). As this project is focused directly on GPs experience of eating disorders and learning from their experiences, it was important that the researcher engaged with the GPs in person as opposed to relying on literature alone or quantitative forms of data. For this reason the interview process was of significant benefit to the researcher. This research report is also a follow on study from a pilot study in 2016 which used quantitative research to investigate GPs knowledge of eating disorders. As this is a follow up study of a quantitative study it was decided that it would be of benefit to the researcher and the eating disorder centre to use the qualitative style interviews, to gain a more in depth view of eating disorders in the primary care setting.

3.46: Disadvantages of the interview

While it has been decided that a qualitative approach would be the most effective and suitable approach there are also ethical considerations and disadvantages to be considered when carrying out qualitative research in the form of semi-structured interviews.

The interview conversation can be framed as a potential source of bias, error, misunderstanding or misdirection, as GPs may not decide to reveal the full extent of their work, due to feeling of incompetency or so as not to display a lack of confidence in the area of eating disorders. Therefore there is a persistent set of problems to be controlled throughout the collection of data (Bryman, 2012).

The issue of reliability and validity also have to be taken into account. Kirk and Miller have defined reliability as the degree to which the finding is independent of accidental circumstances of the research (Kirk and Miller, 1986). This issue is vital to consider as in them the objectivity of social scientific research is at stake.

It has been argued that qualitative data is impressionistic and subjective as qualitative findings rely too much on the researchers unsystematic views about what is significant and

important (Bryman, 2012). This runs in conjunction with Kirk and Miller's view that there is potential for bias in the collection of qualitative data, thus affecting the reliability and validity of the data, which is an ethical concern. It could be possible that the GPs have hidden some aspects of their experience so as not to display a negative impression of themselves, or to appear incompetent. This can be seen as a disadvantage of the interview process in this research design.

Qualitative data is also difficult to replicate as there is rarely any standard procedures to be followed due to the unstructured nature of the interviews and the open-ended questions that the researcher may ask (Bryman, 2012). Therefore the researcher is aware that this study would be difficult to replicate and it is a potential disadvantage of the qualitative semi-structured interviews.

The issue of generalisation also arises as a disadvantage of qualitative data. It is often noted that qualitative data is restricted to small number of participants within a restricted geographical area. It is therefore difficult to know if the results of a particular qualitative study can be generalised to a broader population (Bryman, 2012). The researcher engaged six semi-structured interviews within the Munster area. The researcher acknowledges that this is a restricted number of participants within a relatively restricted geographical domain. The researcher made a conscious effort to interview GPs from both an urban and rural background, however the study would have to be extended to the broader Irish population to make a more generalised conclusion., which is a disadvantage to qualitative data.

The issue of generalisation also arises with the ages of the GPs that were interviewed. The researcher made an effort to interview GPs with a broad age range. Younger GP's education on eating disorders may have differed to those who GP's more mature in age. As well as this, those GPs who are more mature in age may have more practical experience, therefore may have more knowledge in the area of eating disorders. For this theory to be explored a wider sample of GPs would have to be interviewed, therefore it could be noted as a potential limitation to this study.

There also remains an issue of transparency when using qualitative data in research. Bryman noted that it can be difficult to establish from qualitative research what the researcher actually did and how he/she arrived at the study's conclusion as it often not quantifiable (Bryman, 2012). While the researcher has considered all of these limitations, it has to be

acknowledged that there will always be implications in every piece of research. It is the belief of the researcher that the semi-structured style interviews are most applicable to this research design and it will be the duty of the researcher to ensure that, despite the concerns listed, the data gathered will be ethically correct.

3.47: Ethical issues

It was of benefit that this research design consisted of semi-structured qualitative interviews with service providers in the medical profession as opposed to service users. This removed many potential ethical issues. It was the intention of the researcher to involve service users originally in order to help shape the design of the interview questions for the interviews with the GPs. However time constraints became an issue and in order to speed up the process of ethical approval from the ethics committee of University College Cork, the decision was made to exclude service users from the research design as they would be seen as a vulnerable group, ethically speaking. While the exclusion of service users from this research design removed a strong majority of ethical issues, there were still other ethical considerations that had to be taken into account throughout this research design.

3.48: Community based research (CBR)

CARL is a small initiative of mainly academic staff that give their time voluntarily to support Community Supports Organisations (CSOs), in the surrounding area. Community based research (CBR) initiatives have been proved to be highly productive, cost effective, and good value for money. They are also beneficial for policy development and due to its reciprocal nature are usually beneficial on a broad scale (Bates and Burns, 2012). It is thought to be beneficial to all parties involved as it gives the student the opportunity to access to groups that may be labelled difficult to access. It provides the CSO with the opportunity to expand provision and policy implication and it provides the supervisor with additional supports as well as allowing them the opportunity to interact with a CSO and expand on their own supervision skills (Bates and Burns, 2012)

There are, however, some ethical issues that are associated with CBR and have to be taken into consideration throughout the research design. Ethical concerns in community based research include partnership collaboration and power, community rights, ownership and dissemination of data, findings and publications, anonymity and blurred boundaries between the researcher and researched. While many of these issues raised are applicable to all qualitative data there

still remains excess ethical concerns to be considered that are exclusive to CBR. CBR involve elements of openness, fluidity, and unpredictability of the research process. It is also further complicated by its multi-layered partnerships based on the negotiation of power relationships between diverse groups whilst also being constrained by the rigid structures of research governance (Durham Community Research team, 2011). Ethical concerns are a common feature of every piece of research that is conducted, and CBR have a history of being ethically aware and inherently more ethical than traditional research (Durham Community research Team, 2011). The implicit ethical issues that are often encountered when conducting CBR are issues of partnership, collaboration and power, ownership and dissemination of data, findings, as well as anonymity, privacy and confidentiality.

Each of these present as an area of ethical concern for a strong majority of students who partake in CBPR. Partnership, collaboration and power is a topic that are associated with CBPR as CARL tries to move away from the outside expert and tokenistic involvement. This was significantly applicable to this particular research design as it involved a bottom up approach by basing the research on GPs within the medical profession as opposed to focusing on service users (Bates and Burns, 2012). This element of CBPR is important as it illuminates the importance of relationships based on mutual understanding and respect for difference and how these can develop into effective partnerships that address the needs and interests of academics and community partners (Durham Community Research team, 2011). There is also the ethical issue of ownership and dissemination of data, findings and publications which arguably has added complexity when working with the community partnership research. Quigley argued that the most problematic areas of research ethics in communities are about data control, confidentiality, interpretation of results, ownership, publication of results and dissemination procedures (Quigley, 2006).

The researcher has taken these ethical barriers into consideration and is aware that there may be publications of this research design on a wider scale. During the interview process a situation may arise where a name of a patient/client is mentioned accidentally or a private detail regarding a patients/clients treatment plan is mentioned. To combat this issue the researcher has ensured the highest level of anonymity as possible when the data is disseminated and published. This will be achieved by excluding GPs names or any names mentioned during the interview process from the research design. While the issue of anonymity is central to every piece of research it is an elevated issue within community research due to the wide dissemination within the community that is the focus of the research (Durham Community research team, 2011). To combat this issue the researcher has made the participants aware that the research design is

being carried out through the CARL initiative and there was an awareness and explanation of community risks and benefits as well as issues of anonymity coercion and voluntariness.

3.49: Limitations to the study

This research design was largely exploratory in nature. While this research project is based on a pilot study of two years previous, it is adapting a different method of data collection and it is therefore met with its own set of limitations. As with any piece of research there were limitations that had to be considered. A significant limitation to this study arose in the process of interviewing GPs. The researcher had to take a number of steps to make contact with the GPs. The researcher originally decided to make contact with the GPs via email, which were obtained randomly from Health Service Executive and Irish College of Practitioners websites. However due to time gaps in the response rate it was decided to ring the GPs. This was a limitation to the research process as it hindered the development of the research design as the researcher had to wait on the GPs to respond in order to arrange a time for interviews.

Limitations also arose, due to the fact that many GPs felt they were unable to facilitate an interview. This could be due to varying reasons. While none of the GPs disclosed the specific reason as to why they could not facilitate the interview, it is thought that it was due to time constraints. The workload that GPs are faced with means they have little spare time, and this could have been a possible reason as to why they could not facilitate the interview. Another possible reason could be due to the fact that those presenting with eating disorders in Primary care are still low in prevalence, which has been documented in the literature discussed in the previous chapter. Due to the low prevalence of eating disorder cases it may be possible that GPs did not feel confident facilitating an interview.

The researcher acknowledges that there was a number of restrictions put in place throughout this research design that are presented as limitations to the study. One such restriction was the decision to interview six GPs in the Munster area. The researcher acknowledges that due to the short time space with which to submit the research that four GPs in the Munster area would have to suffice. However this could present as an issue with regard to generalisation. Four GPs is a relatively small group to research and the geographical location of Munster is also a restriction. The researcher is aware that for this reason, the study cannot be generalised to an entire population but that it could help in further future studies.

3.5: Conclusion

This chapter explored the methods that the researcher adapted in order to carry out this research. This chapter highlighted the advantages of the qualitative method that was used as well as the limitations to the study that became apparent to the researcher. This study was a follow up from a pilot study on GPs knowledge of eating disorders. As a result of this, it is still largely exploratory in nature and has many limitations that have been identified in this chapter. This was a quantitative study on GPs knowledge of eating disorders within the Cork area. While replication of a semi-structured interview has been noted as a limitation and may not be possible, similar studies could be carried out without them being a direct replica. There is always limitations that exist with any research design that is carried out. The researcher has acknowledged these in this chapter and it is hoped that they could be used as possibilities for future research in the area of eating disorders.

Chapter 4: Findings and Analysis

4.1: Introduction

This chapter will focus on the findings that came about as a result of the qualitative interviewing process. The chapter highlights the main themes that arose and then analyse these findings while referring to the relevant literature discussed in previously in this report. The researcher conducted four interviews with GPs from a variety of practices around the Munster area, of all age's ranges and both sexes. This chapter will outline and present the findings from these interviews, and a thematic analysis will be drawn. This will emphasise and record patterns or themes that emerged throughout the interviewing process. The main themes that will be discussed are GPs knowledge of eating Disorder, time constraints, lack of integration of services, the challenging eating disorder patient and stigma.

4.2: GP's knowledge of eating disorders

This study was largely informed by McDermott's study in 2016, which focused on GP's knowledge of eating disorders. McDermott's study found that only 13.9% of GPs surveyed in the Cork city and county area had received some form of training on eating disorders. The lack of training and education that GPs received proved to be a recurring theme in these interviews. While all of the GPs agreed that they felt they were in a good position to diagnose an eating disorder they all highlighted the lack of training they had received in the area. Participant C stated that "exposure to eating disorders in college was very limited", she added that in all her years of attending additional training courses she had "never done a teaching course on eating disorders" Participant D felt that "GPs are in a good position to deal with eating disorder cases as GPs can build up a good rapport with the ED patient, hence building trust and a more open communicative relationship", yet he highlighted that they only received a small amount of information on eating disorders through their psychiatry rotation, stating he learnt more "through years of practice and experience", this can present as a problem for those GPs who are new into the field of practice and lacking experience. Participant B also mentioned that she had learned little on eating disorders, besides "a two hour lecture as part of their psychiatry rotation", and she felt that eating disorders are a "niche area, if you aren't practicing it all the time then your skills are limited". Participant A has been a GP for more than thirty-five years and he felt that he learned most through his experience in practice. This issue could also be due to the varying ages of the GPs. Each of their educational experience differed depending on the time they were in third level education. While some GPs noted that they had learned more from

experience through years of practice, those GPs who have less years of practice experience would have had a greater exposure to mental health in their educational training. All of the GP's interviewed for this study stated the need for more education that would help to aid the early intervention process, yet they also felt there was a need for better integration of services so that there wasn't an increased burden of expectation placed on GPs. Participant A stated that "there is often too much expected of GPs, as they are invited to educational medical talks on a range of different topics". It would be unrealistic to think they can attend everything. Participant B highlighted that while she felt the GP would be a good place to initiate treatment, she felt that there is a "need for greater community supports who specialise on the topic of eating disorders".

Within the theme of GPs knowledge on eating disorders, the topic around the dissemination of eating disorder guidelines came up. As discussed in the policy review of this research report, Bodywhys (2016), published an online information leaflet on eating disorders for GPs. However Currin et al (2007), has found that GPs do not routinely use published guidelines. Participant A highlighted that while guidelines can be useful, they have to be succinct as a GP simply does not have the time with which to study dense guidelines that consist of a thirty-six page online leaflet, when they have such a wide range of illnesses and disorders to deal with. Participant B highlighted that "while guidelines are useful you have to include your own clinical judgement too". Both Participants B and C felt that while the guidelines, which state diagnostic criteria of EDs, can be helpful but they cannot help GPs to acquire the skills needed to communicate with the ED patient as they give little information on how best to manage the ED patient. They are also not widely advertised as participant A stated he knew about the NICE guidelines but was unaware of the Irish guidelines. Participant D also stated that he was not aware of the online guidelines.

4.3: Time constraints

Linville et al (2010) stated that screening for an eating disorder can be time consuming in comparison to other illnesses and disorders, as they are complex patients who often practice a high level of deniability of their disorder. This affects the early identification process of eating disorders in the primary care setting as it is not possible to assess the needs of complex patients in a ten minute appointment (Siddique, 2016). Participant A stated that, "You must listen to the patient and learn from them, they're the experts of their own body"

While in theory this idea is very appropriate and holistic in nature, the reality is often unrealistic as participant B noted that “the GP has to deal with patients on the spot, making an immediate judgement”.

Participant B is also a consultant cardiologist and she noted that in the secondary care setting, one is dealing with referrals and therefore have more time to assess the health profile of the patient or engage in some research. However GPs do not have the time to do so, as they meet patients in a ten minute appointment. These appointments are restricted due to the heavy workload GPs face and there isn’t time to “read all the resources made available online, as well as listen to family concerns and build a rapport with the patient/client” (Participant A).

The interviews highlighted that GPs are often challenged with an overburdening workload as one participant C stated that on one particular case she spent “hours” of her afternoon off calling specialists and researching information for her patient who she suspected had an eating disorder.

4.4: Services

“Services are desperate, I had to admit one adolescent to A&E just to access CAMHS”¹⁷

All of the GPs interviewed mentioned the lack of adequate services available to them when presented with a patient/client who may be presenting with an eating disorder. Participant C stated that she felt a person would have to be a crisis point just to be seen in a specialist service. She added that even when the patient is seen by a specialist, they can often be in the wrong service, with one of her adolescent patients being referred to an adult psychiatric ward, which she described as “inappropriate”. Participant D disclosed that this often happens due to the long waiting list for CAMHS. Participant D stated that “publicly you are very limited with what you can do unless they go down the private route. Waiting lists for CAMHS are 12-18 months”. The GPs found this extensive backlog in services particularly worrying as there is such a high mortality rate associated with eating disorders. Participant C disclosed that she was worried that one of her patients would die while waiting on the specialist services to see her.

The fieldwork research carried out also found that GPs felt unsupported in the area of eating disorders. Participant B stated that “as a general physician we feel unsupported in the area of psychiatry”. While she highlighted that she felt GPs should be “the co-ordinators of supports” she felt that there is a need for greater community supports to ensure a more efficient service.

¹⁷ Child and Adolescent Mental Health Services.

Participant A shared a similar view stating that “the specialist services are area dependent”. He felt there was an overall lack of coordination in all areas of the Irish healthcare system and there was a need for “greater community supports”. All participants highlighted the need for greater community supports and better coordination of services. Participant C stated that “there is a need for a liaison person, there is no point of contact”. Participant D shared similar concerns voicing his frustration at trying to liaise with Dublin in order to refer patients presenting with an eating disorder.

4.5: The challenging Eating disorder patient/client

“The problem isn’t the eating disorder itself, but the feeling of unhappiness associated with it” (participant A)

A review of the literature revealed that many healthcare professionals, such as GPs and doctors in the secondary level healthcare setting avoid working with ED patients (Linville, 2010). While none of the participants admitted to avoiding working with ED patients they all made reference to the difficulty involved in ED cases. Pentony (2012) argued that ED patients have been inaccurately stereotyped as difficult to communicate with, this was made evident by the GPs who participated in the research, with all participants referring to the difficulty of body dysmorphia¹⁸ associated with an ED resulting in a high level of deniability. Participant D admitting it was difficult to “get the person to accept they have an eating disorder” he stated that those suffering with an ED will often lie about what there are eating, admitting that “one of my patients put stones in his pockets when being weighed” . The high level of deniability associated with ED sufferers has an effect on the communication and rapport building process between the GP and the person who may be suffering with an ED. Participant B stated that “they are complex patients who are difficult to communicate with”. She expressed frustration as she stated that “you feel like you’re getting through to them but you’re not”. Participant C stated a similar worry as she expressed that “It is difficult to see this person disappearing in front of you”.

The highly comorbid nature of an ED was also mentioned as a barrier to communication with an ED patient. Participant A stated that the difficulty isn’t the eating disorder itself but the emotional and psychological problems that create a barrier to treatment. Participant B admitted

¹⁸ A body image disorder that is characterised by persistent and intrusive preoccupations with an imagined or slight defect in one appearance.

the difficulty involved in treating both the physical and psychological aspect of the disorder, which she felt she “did didn’t have the communication skills for”.

4.6: Stigma

According to (author, 2017), “Medical professionals often hold negative attitudes towards patients with eating disorders and are ill-equipped to treat them”. The review of the current literature highlights that GPs often hold negative attitudes towards patients with an ED. McNicholas (2016) found that stigma and stereotypes influence Health care professionals’ clinical and interpersonal interactions. Despite these findings, the researcher found that none of the GPs interviewed appeared to hold negative view towards ED patients. However they did mention that stigma on the topic of eating disorders is still prevalent and this can result “in huge difficulty in trying to get someone to admit to having an eating disorder”. Participant A stated that “the media is corrupting their (ED patients) minds to a state where their minds are fixed on that”. He elaborated by stating that the media plays a central role in the manifestation of an eating disorder which can often lead people to think that eating disorders aren’t anything but a direct result of vanity which is far from the truth. Doctor Sara McDevitt from the college of Irish Psychiatrists stated that a strong majority of Irish society often fail to equate eating disorders with mental health issues. Participants in this research felt they were in the best position to be involved in the first point of contact of an eating disorder, however they felt that it was due to the stigma around eating disorder and often society’s unwillingness to take the issue seriously that often prevents people from seeking help for an ED.

Chapter 5: Discussion and Recommendations

Introduction

The main aim of this research project was to explore the factors that may prevent a GP from the early identification of an eating disorder. The participants in this research design made some recommendations that they feel could be implemented to improve the overall support services in the area of eating disorders which would in turn aid the early intervention process of eating disorders.

5.1: Education

More education and training on the topic of eating disorders, in both educational institutions and within the community. It is needed for both those students training in the the medical profession as well as for those already working in the medical setting. While all GPs highlighted that they would welcome more education/training on eating disorders, the forms of education they proposed varied. Participant A highlighted the need to learn from patients. This may involve service user involvement, by sharing their experience with their own eating disorder in an open discussion forum. This could also help to reduce the stigma around the area of eating disorders.

Participant B, stated that she would need a training course on communication skills specifically designed to deal with those who are struggling with an eating disorder. She felt she was confident in identifying the symptoms of an eating disorder but was unsure as to how to approach the subject and communicate with them. Participant C, voiced a similar concern as she was not confident in how to communicate her support to the patient or the family of the patient who she felt also needed a significant amount of support throughout the process. Participant D felt that education in any form is good, but argued that it would have to be flexible and online so as to suit GPs busy schedule.

5.2 Online Guidelines

All GPs highlighted the need for online guidelines that would provide a universal criteria for eating disorder patients to meet in order to make a referral. It was suggested that something similar to the NICE guidelines be implemented into Irish society. They stated the need for them to be succinct and effective. While many of the participants were aware of the Bodywhys guidelines they stated that they were too dense to use as a quick reference. The

participants also mentioned the ICGP¹⁹ guidelines, however they highlighted the issue that there is no set coordinated approach, which could be implemented by coordinating the guidelines and condensing them to make them more user friendly.

Participant C also suggested online referral forum where the GP could fill out a form online, stating the symptoms and worries in order to speed up access to secondary care services. She suggested a more streamlined service for eating disorders as GPs often don't know where to refer to patient suspected of having an ED. However this would be difficult without adequate services to support it.

5.3 Integration and Coordination of Services

All of the participants highlighted that lack of integration and coordination of services on the subject of eating disorders. They highlighted the need more community supports as well as a liaison officer in the area who would deal with eating disorder services. While there is a need for a professional medical opinion on issues associated with eating disorders, there is also other aspects needed to help treat eating disorders. There are numerous voluntary organisations that specialise on the topic of eating disorders that GPs felt could be better utilised to help them feel better supported in the area. The participants in this study felt that if they felt better supported in the area of eating disorders that they would feel more confident in diagnosing and treating eating disorders. An integrated and interdisciplinary approach is needed to treat disorders as mentioned in the review of the literature. Eating disorders need to be treated with a biopsychosocial approach therefore the integration of services could be useful in aiding the early intervention process of an eating disorder.

¹⁹ The Irish College of General Practitioners.

Chapter Six: Conclusion

This study has succeeded in identifying possible factors that may hinder the early identification process of eating disorders in the primary care setting. It has shown that there are many factors present that can hinder the early identification process of an eating disorder in the primary care sector.

This study has identified a number of recommendations that could aid the early identification process of eating disorders, which could help tackle the pressing issue of eating disorders and the estimated 200,000 currently suffering with some form of eating disorder in Irish society (A Vision for Change, 2006). These recommendations are an invaluable asset to this study as they have been suggested by the GPs themselves.

However it must be recognised that this was a small scale undergraduate study, with limited time and resources. The results from the six GPs interviewed does not accurately represent the entire GP population of Ireland. Therefore it would be recommended that future studies would conduct research into this area, possibly in postgraduate studies where there is a more realistic time frame with which to conduct fieldwork. Further research in this area could incorporate a mixed methods approach as opposed to previous studies which have been primarily quantitative or qualitative in nature. Further research could also include a broader geographical domain than just the Munster area, as well as getting more GPs involved in the study. Overall, it has been shown that there is a number of factors that can prevent GPs from the early identification of eating disorders in their patients/clients. This study, as well as McDermott's (2016) study of two years previous, has highlighted the significance of the early identification process in eating disorder cases and therefore some changes must be implemented to aid the early identification process of eating disorders. If there is some change brought about in this area it could have a significant impact of the increasing prevalence and fatality of eating disorder cases in Ireland.

This study could be used as a foundation for future studies that could extend beyond the Munster area, and include a larger number of research participants with a longer timeframe with which to complete the research.

Overall, it can be seen that there are many factors involved in hindering the early identification process of an eating disorder in the primary care setting. It is evident that some

changes need to be implemented in order to address the significant health concerns that manifest as a direct result of eating disorders. With an estimated 1757 new cases of new ED cases set to emerge in Ireland in the 10-49 age group each year (Bodywhys, 2017), it is clear that this issue needs to be tackled. Better coordination and integration of the healthcare services in Ireland needs to be implemented in order to bring about a more efficient healthcare system for ED sufferers as well as the general population. Both GPs, family, friends and those suffering with an ED need to feel supported and encouraged. This can be done through better communication and utilising the services available as opposed to placing blame on the primary healthcare service. This research design was based on McDermott's (2016) study that hypothesized that there was a lack of knowledge on eating disorders among the Irish GP population. There is a lack of education on the subject but not just among GPs, but among the general Irish population too.

Participant A stated '*we must listen to the patient, learn from the patient*'. There is many different forms of education, the patient must learn from the GP and the GP can in turn learn from the patient. Once this form of education is utilised and accepted, a more effective system can be developed and accepted in order to create an open environment to aid the early identification of an eating disorder.

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Appendices:

Information sheet for GPs

Title of research:

What can prevent General Practitioners from the early identification of an eating disorder in their patients/clients? A small scale qualitative study of Munster based GPs.

Dear Sir/Madam,

My name is Cadhla O'Sullivan and I am currently in my final year of a Social Science Degree in University College Cork. It is a requirement of this course that we complete a final year piece of research. Together with my supervisor, Mr. Robert Bolton, I have decided to complete my final year research project on Eating Disorders.

It was brought to my attention that the Eating Disorder Centre Cork (EDCC), were trying to work with third level students through the CARL (Community Academic Research Links) initiative, which is a small initiative of mainly academic staff who voluntarily give their time to help CSOs. Having met with Trish Shiel, central director of the EDCC, it was decided that I would conduct semi-structured interviews with Munster based GPs in order to gain further insight into what can prevent GPs from the early identification of eating disorders.

I will reiterate what is stated in the consent and information form, which outlines that all research participants are partaking on a voluntary basis. The issue of anonymity will be a priority throughout the duration of this research. It is also important to note that any research participant can refrain from answering any interview questions and that they are also entitled to withdraw their consent up to two weeks after the interview has been conducted.

I look forward to working with all research participants with the intention of producing a clear, concise and beneficial piece of research for my own educational attainment as well as for the EDCC, in the hope it will be used for future research and general societal advancements. If you have any further queries please do not hesitate to contact myself or my supervisor on the contacts provided below:

Cadhla O'Sullivan- 086 249 4842

Email- 115531697@umail.ucc.ie

Robert Bolton- 111428692@umail.ucc.ie

Thank you for taking the time out of your busy schedule, it is much appreciated.

Kind regards,

Cadhla O'Sullivan,

B.Soc III student,

University College Cork 2015-2018.

School of Applied Social Studies Ethics Form

		YES	NO	N/A
1	Have you discussed your proposed research and your ethical review with your supervisor?	X		
2	Do you consider that this project has significant ethical implications?		X	
3	Will the main research procedures be outlined to potential research participants in advance, so that they are informed about what to expect?	X		
4	Will research participation be voluntary?	X		
5	Will informed consent be obtained in writing from research participants?	X		
6	Will you tell research participants that they may withdraw from the research at any time and for any reason, and (where relevant) omit questionnaire items/ questions to which they do not wish to respond?	X		
7	Will data be treated with full confidentiality/ anonymity (as appropriate)?	X		
8	Will data be securely held for a minimum period of ten years after the completion of a research project, in line with the University's <i>Code of Research Conduct</i> (2016)?	X		
9	If results are published, will anonymity be maintained and participants not identified?	X		
10	Will participants be debriefed at the end of their participation (i.e. will you give them a brief explanation of the study and address any concerns they may have after research participation)?	X		
11	Will your project involve deliberately misleading participants in any way?		X	
12	Will research participants include children/ young persons (under 18 years of age)?		X	
13	If yes to question 12, is your research informed by the UCC <i>Child Protection Policy</i> ? http://www.ucc.ie/en/ocla/policy/			X
14	Will your project require you to carry out "relevant work" as defined in the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016?			X
15	Do you require official Garda Vetting through UCC before collecting data from children or vulnerable adults?		X	
16	Will research participants include people with learning or communication difficulties?		X	
17	Will research participants include patients/ service users/ clients?		X	
18	Will research participants include people in custody?		X	
19	Will research participants include people engaged in illegal activities (e.g. drug taking, illegal Internet behaviour, crime, etc.)?		X	
20a	Is there a realistic risk of participants experiencing either physical or psychological distress due to research participation?		X	
20b	Is there a realistic risk of you, as the researcher, experiencing either physical or psychological distress?		X	
21	If yes to question 20a, has a proposed procedure for linking the participants to an appropriate support, including the name of a contact person, been given?			X
22	If yes to question 20b, has a proposed procedure/support structure been identified?			X
23	Are the research participants also students with whom you have some current/previous connection (class members, friends, tutor, etc.)?		X	
24	Will research participants receive payment/ gifts/ vouchers/ etc. for participating in this study?		X	

25	Are you accessing, collecting or analysing confidential agency documents or case files? If yes, please give details of compliance with the agency's policy on data protection and confidentiality below in your review.		x	
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PART A: DESCRIPTION OF THE PROJECT

Ethical review requires that you **reflect** and seek to **anticipate** ethical issues that may arise, rather than reproduce copious text from existing research proposals into these boxes. Entries should be **concise** and relevant to the point/ question.

A. Very brief description of your study (15-25 words max.)

[e.g. This is a narrative literature review (desk-based) examining group work interventions with young people on the theme of sexual health]

A qualitative investigation into the factors that can prevent General Practitioners from the early identification of an eating disorder in their patients/clients.

B. What is your study about? (Aim and Objectives / Key Research Questions) (100-150 words max.)

The aim of this research is to gain further insight into what can prevent a General Practitioner from the early identification of an eating disorder in their patients/clients. It is the intention of this research to carry out a small number of semi-structured interviews with General Practitioners, in order to explore the perceived difficulties that General Practitioners face when dealing with patients who may be presenting with symptoms of an eating disorder in terms of diagnosis, referrals and treatment. It is hoped that this research design will highlight the difficulties General Practitioners have to deal with when presented with an Eating Disorder Patient and what is needed to address these difficulties.

C. Concise statement of anticipated ethical issues raised by your project. How do you intend to deal with them? For example, your research could be desk-based but may still involve sensitive/ controversial material (100-150 words max.). In relation to any kind of research with human subjects you need to address the issue of **informed consent** and how that will be addressed, **safe data storage** for the duration of the project and beyond and how you will safeguard the **rights and welfare of research subjects**. If research is being conducted with **any** human subjects, information leaflets, consent forms etc., which have supervisor oversight, should be routinely used.

The anticipated ethical concerns that may arise throughout this research design is the issue of anonymity. This concern might arise if the General Practitioner accidentally mentions patient's/client's names or provides a case study of a patient in which the material could enable the identification of the patient. I will ensure that all names are anonymised, and I will ensure that no potentially identifying material is included in the final dissertation.

Participants involved in the research will be partaking on a voluntary basis, having received information on the research, consent forms and evidence of ethical approval.

Any data obtained throughout the research project will be stored safely for the duration of ten years. Research participants have the right to refrain from answering any question, they can also withdraw from an interview as well as withdraw consent up to two weeks after the interview has taken place.

INFORMATION SHEET

Purpose of the Study.

As part of the requirements for Bachelor of Social Science (Hons) degree at UCC, I have to carry out a research study. The study is concerned with the perceived difficulties relating to

issues of diagnosis, referral and treatment that General Practitioners are presented with when dealing with patients/clients who are/maybe struggling with an eating disorder.

What will the study involve?

The study will involve semi-structured qualitative interviews with General Practitioners in the Munster area in order to gain further insight into what can prevent General Practitioners from the early identification of an eating disorder in their patients/clients.

Why have you been asked to take part?

You have been asked because you are specifically suitable to this research design as it a study based primarily on General Practitioners experience of dealing with issues relating to eating disorders in their practice.

Do you have to take part?

You do not have to partake in this study as participation is voluntary. You will be provided with an information sheet on the research design as well as a copy of the consent form, which you will be asked to sign if you see fit. It is important that participants are made aware that they do not have to answer any questions that they may not approve of. Participants can withdraw from the interview before the study commences, and they can also withdraw consent and have their data destroyed up to two weeks after the interview has been undertaken.

Will your participation in the study be kept confidential?

Yes. Although there is never a guarantee of complete confidentiality within social research, I will take step ensure that no clues to your identity will appear in the thesis. Any extracts from what you say that are quoted in the thesis will be entirely anonymous.

What will happen to the information which you give?

The data will be kept confidential for the duration of the study, available only to me and my research supervisor. It will be securely stored, on a USB key and will be also be backed up on

a hard drive. On completion of the project, they will be retained for minimum of a further ten years and then destroyed.

What will happen to the results?

The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study may be published in a research journal, or the ICPA as some previous studies have been published on this as requested by the Eating Disorder Centre Cork who I will be working with on this research design as part of the Community Academic Research Links (CARL).

What are the possible disadvantages of taking part?

I don't envisage any negative consequences for you in taking part.

Who has reviewed this study?

My research supervisor, Robert Bolton has reviewed and approved this study. Approval must be given by my supervisor, Mr. Robert Bolton, as well as the Social Research Ethics Committee of UCC before study takes place.

Any further queries? If you need any further information, you can contact me:

Name: Cadhla O'Sullivan

Email address: 115531697@umail.ucc.ie

You may also contact my supervisor, Mr. Robert Bolton, if you feel the need to do so.

Email: 111428692@umail.ucc.ie

CONSENT FORM

This consent form is designed with qualitative research in mind. Where quantitative methods are used, issues such as quotations and audio-recording do not arise.

I.....agree to participate in Cadhla O'Sullivan's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Cadhla O'Sullivan to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks (14 days) of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview

I do not agree to quotation/publication of extracts from my interview

Signed:

Date:

PRINT NAME: